COMPASS MEDICAL PC
Exceptional Medicine. Compassionate Care.

Medical Record # _____
To be completed by Compass Medical Staff

ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically. Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

CONSENT TO DISCLOSE PROTECTIVE HEALTH INFORMATION TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES

THIS FORM IS OPTIONAL

Patient Name:_____ Date of Birth: _____

By signing below, I hereby authorize Compass Medical, P.C. to disclose my protected health information (PHI) to the following family members, friends etc.

Name	*Relationship*	*Phone Number*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature:_____ Today's Date: _____

By signing below, I hereby authorize the Providers and staff at Compass Medical, P.C. to leave information on my answering machine.

Patient Signature:_____ Today's Date: _____

Note: This form will be in effect until a verbal or written request has been received to revoke and/or change.

**The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule under the governance of the Office of Civil Rights. The Privacy rules defines and limits the circumstances in which an individual's protected health information (PHI) may be used or disclosed. By completing this form, you are authorizing Compass Medical Providers and Staff to communicate with the individuals you have identified above about your Protected Health Information (PHI).*